Automated Health Systems, Inc - NJ VFC
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Pittsburgh, PA 15237
1-877-900-4VFC (1-877-900-4832)

VACCINES FOR CHILDREN PROGRAM
ELIGIBILITY/VACCINE ENCOUNTER RECORD

IMPORTANT: The entire form MUST be completed and submitted monthly. ** NOTE: *For entry into the NJ Immunization Information System (Registry) the patient and provider information listed directly below must be completed each time the child receives vaccine.*

PLEASE PRINT LEGIBLY!

Name of Recipient (Last, First, MI)	Date of Visit ____ / ____ / ____ Mo. / Day / Year

Vaccine Recipient's Address and Zip Code (Optional)	Recipient's Date of Birth ____ / ____ / ____ Mo. / Day / Year	Age (<1-18 Yrs) ____ / ____ Years / Months

VFC Provider Identification Number (PIN)	Name of Facility or Provider (Last, First, MI)

The questions which follow should be asked of the mother/parent/guardian or individual of record granting permission for a child, 18 years of age or younger, to be immunized. These simple screening questions should be used by the health care provider, **on each visit date** before vaccinations are administered, to determine if the child is eligible for immunization through the VFC Program. While verification of the responses is not required, it is necessary to retain this or a similar record for each child receiving the Federal vaccine.

➜ **IMPORTANT: Must fill in this section.**

The individual qualifies for vaccines thorough the VFC Program because he/she:

A ☐ Medicaid, Medicaid Managed Care, and NJ KidCare Plan A Medicaid Number: _____ (Optional)
B ☐ NJ KidCare Plans B, C & D
C ☐ has no health insurance
D ☐ is an American Indian or Alaskan Native
E ☐ has health insurance that does not pay for vaccine *(NOTE: These individuals can only receive vaccine provided through the VFC Program at a FQHC such as a community/migrant/rural health center.)
F ☐ 317 funds *(NOTE: Only available to local health department operated sites if the five eligibility criteria listed above are not met, or by special permission of the N. J. Immunization Program.)

Vaccine (s) Administered This Visit (Check ALL appropriate boxes)

	DOSE 1	DOSE 2	DOSE 3	DOSE 4	DOSE 5
DTaP	[ ]	[ ]	[ ]	[ ]	[ ]
DTaP/Hib					[ ]
DT (Pediatric)	[ ]	[ ]	[ ]	[ ]	[ ]
Td (Adult)	[ ]	[ ]	[ ]	[ ]	
Pediarix	[ ]	[ ]	[ ]		
Hib	[ ]	[ ]	[ ]	[ ]	
Hib/Hepatitis B	[ ]	[ ]	[ ]	[ ]	
Pneumococcal Conjugate	[ ]	[ ]	[ ]	[ ]	
E-IPV	[ ]	[ ]	[ ]	[ ]	
MMR	[ ]	[ ]	[ ]		
Measles	[ ]	[ ]			
Hep-B	[ ]	[ ]	[ ]		
Hep-B (2 Dose)	[ ]	[ ]			
Hep-B (Adult)	[ ]	[ ]	[ ]		
Hep-A.(Pediatric)	[ ]	[ ]			
Hep-A.(Adult)	[ ]	[ ]			
Varicella	[ ]	[ ]			
Other _____	[ ]	[ ]	[ ]		

**The provider AND mother/parent or guardian grant permission for the recipient's immunization data given above to also be included in a New Jersey Immunization Information System when operational. ☐ Yes ☐ No

Distribution: Original - Contractor/NJDHSS (Batched)
Copy - Provider/Patient's Medical Record